Schedule of Medical Fees

December 1, 2005

Kansas Department of Labor
Workers Compensation

KANSAS DEPARTMENT OF LABOR

DIVISION OF WORKERS COMPENSATION

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The Kansas Workers Compensation Schedule of Medical Fees incorporates portions of the following documents:

1. The *Current Procedural Terminology,* Fourth Edition, copyright 2004 (a.k.a. *CPT* 2005) by the American Medical Association
2. The *Current Dental Terminology, CDT-2005,* copyright 2004, published by the American Dental Association
3. The *Relative Values for Dentists 2005*, copyright 2004, published by Relative Value Studies, Inc. of Broomfield, Colorado
4. The *2005 Relative Value Guide*, copyright 2004, developed by the American Society of Anesthesiologists
5. The *2005 Essential RBRVS*, A comprehensive listing of RBRVS values for *CPT* and HCPCS Codes, copyright 2004 Ingenix, Inc.
6. The *2005 HCPCS* allowances that were obtained from Cigna HealthCare who is under contract with CMS as the Durable Medical Equipment Regional Carrier (DMERC)

Some of the most important revisions that have been incorporated within this Schedule of Medical Fees are as follows:

1. Incorporation of the RBRVS concept for improvement in the statistical validity is used for the unit values employed to determine maximum allowable fees.
2. Expansion and refinement of the DRG based reimbursement system for hospital inpatient care has been updated to coincide with the most recent data available at the time of this publication.
3. Medical Nutrition Therapy has been added as a new section within the fee schedule. A Conversion Factor of $41.19 has been established.
4. Acupuncture has been added as a new section within the fee schedule. A Conversion Factor of $41.19 has been established.
5. The Conversion Factor for the various sections of the fee schedule (except for Anesthesia) has been changed as follows to reflect the incorporation of the RBRVS system.

   Surgery: Conversion Factor changed from $110.00 to $67.95
   Radiology: Conversion Factor changed from $110.00 to $63.15
   Pathology: Conversion Factor changed from $110.00 to $75.10
   Medicine: Conversion Factor changed from $82.50 to $52.42
   Physical Medicine: Conversion Factor changed from $50.00 to $43.80
   Osteopathic Manipulative Treatment: Conversion Factor changed from $60.00 to $54.43
   Chiropractic Manipulative Treatment: Conversion Factor changed from $53.50 to $50.75
   Special Services and Reports: Conversion Factor changed from $30.00 to $42.35
   Evaluation and Management: Conversion Factor changed from $25.00 to $46.33

6. The Conversion Factor for Anesthesia has been changed from $45.00 to $48.75.
7. A new payment schedule for nurse anesthesists has been introduced; i.e., payment will be limited to 85% of the maximum allowable fee associated with the *CPT* code used for billing.
8. A new payment schedule for physician assistants or advanced practice nurses has been introduced; i.e., payment will be limited to 85% of the maximum allowable fee associated with the particular *CPT* code used for billing.
9. The Ground Rule within the Surgery Section that related to Starred Procedures has been deleted to correspond with the changes made by AMA in conjunction with *CPT* 2004.
10. A new column identified as "FUD" has been added in the Maximum Allowable pages of the Surgery Section to specify the amount of follow-up days that pertain to a particular type of surgical procedure and/or service.
11. A new rule pertaining to Conscious Sedation has been included in the Surgery Section of the fee schedule.
12. A new column identified as "PC/TC" has been added in the Maximum Allowable pages of the Radiology Section to specify the percentage amount or split for the Professional Component and the Technical Component with respect to each of the *CPT* codes.
13. The special exception for *CPT* code 97534 found within the Physical Medicine Section has been deleted from the fee schedule.
14. The Dentistry Section of the fee schedule has been changed to reflect that dental services will no longer be subject to any discount/reduction as it relates to Bilateral or Multiple Procedures. Modifiers -50 and -51 that were used to report any bilateral/multiple services are no longer a part of the dental fee schedule. Also, the Conversion Factor has been changed from $33.00 to $35.75.
15. The Hospital/Ambulatory Surgical Center of the fee schedule has been changed whereby Ambulatory Surgery Centers within Peer Groups 1 and 2 are now specifically being listed.
16. The Medical Equipment and Supplies Section has been amended to now include the maximum allowance for any prosthetic and/or orthotic devices. The maximum payments as listed have been computed by using the 2005 HCPCS rates obtained from Cigna HealthCare, who is under contract with CMS as the Durable Medical Equipment Regional Carrier (DMERC) and increasing those rates by 25%.
17. The maximum allowances for Vocational Rehabilitation Services have been increased by 10%.

First Edition Printed - November 1993
First Revision - May 1996
Second Revision - September 1997
Third Revision - October 1999
Fourth Revision - December 2001
Fifth Revision - December 2003
Sixth Revision - December 2005

This Schedule of Medical Fees, planned for implementation December 1, 2005, was approved by the Workers Compensation Director on July 27, 2005.

The most recent contract agreement between the American Medical Association (AMA) and the Kansas Department of Labor prohibits the fee schedule inclusion of individual *CPT* code descriptions. This is a new policy decision by the AMA and will similarly apply to other jurisdictions that publish medical fee schedules for Workers Compensation. For the applicable *CPT* 2005 Code

descriptions, refer to the *Current Procedural Terminology*, copyright 2004 (a.k.a. *CPT* 2005), available through the American Medical Association.

Although the American Dental Association contract agreement does not prohibit the inclusion of *CDT* code descriptions, those descriptions will not be included within the fee schedule, so as to maintain a uniform presentation format for all codes employed to obtain reimbursement for services provided. For the applicable *CDT* code descriptions, refer to the *Current Dental Terminology, CDT-2005*, available through the American Dental Association.

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INTRODUCTION

In accordance with the provisions of Substitute for HOUSE BILL No. 3069 that was enacted by the 1990 Kansas Legislature, and through the assistance of the advisory panel that was created by law to assist the Director in the establishment of a Schedule of Medical Fees, this fee schedule has been adopted and is to be used as the basis for the billing or payment of medical, surgical, hospital, dental, nursing, vocational rehabilitation, or any other treatment or services that are provided to injured workers under the Workers Compensation Law of the State of Kansas.

This Schedule of Medical Fees governs the medical services provided to injured workers by health care providers including the medical services provided by registered physical and occupational therapists, and the medical services of a hospital or other health care facility; it also governs facilities and agencies providing vocational rehabilitation services. The maximum allowable fees and unit values contained within this schedule, which vary by the specific type of service, take into consideration the difficulty in performing a certain type of service that is based upon the risk, time, ability, and skill involved. Note specifically the code designation by type of service being provided. These codes have been adopted by various medical societies and associations (e.g., American Medical Association, American Dental Association) and are to be used in the respective billing or payment of medical services involving injured workers. **Note: The maximum allowable payment to a physician is to be limited to the maximum allowable payment contained within the appropriate sections of this fee schedule, regardless of who either bills for the service or where the service(s) was/were provided. Billing for all physician services, whether provided in a physician's office, hospital, or any other setting, must be submitted using the CMS 1500 form or an equivalent form containing the same information. Additionally, and to assure that Cost Containment is achieved, nothing in this fee schedule shall preclude an employer (or insurance carrier) from entering into payment agreements to promote the continuity of care and reduction of health care costs. Such payment agreements, if less, will supersede the limitation amounts specified herein. Please refer to K.S.A. 44-510i(e) for further clarification, if necessary.**

The maximum allowable payment for physician assistants or advanced practice nurses is limited to eighty-five percent (85%) of the maximum allowable fee associated with the *CPT* code submitted.

The unit values for the respective *CPT* codes listed within this Schedule of Medical Fees expresses the relativity, based on comparative magnitude, between various procedures and services. Thus, the maximum fee schedule amount for a particular procedure or service is determined by multiplying the listed unit value by the applicable conversion factor for the section in which the service or procedure is located. See the "Conversion Factors" at the end of this Introduction Section for the applicable conversion factors.

With regard to Anesthesia, the Basic Unit Values contained within the Anesthesia Section of this Schedule of Medical Fees were obtained from the *2005 Relative Value Guide* developed by the American Society of Anesthesiologists (ASA), which is recognized as an appropriate assessment of current relative values for specific procedures related to anesthesiology.

The accompanying General Instructions, and Ground Rules that are applicable to each section, explain the application of the *CPT* codes and unit values. It is important to remember that this fee schedule has been developed anticipating that it can be used by all health care providers. Note, however, that appropriate surgical codes are not confined to use by surgeons, nor are the Medicine or Evaluation and Management Sections confined to use by specialists, internists, etc.

Since this fee schedule is applicable to the entire state of Kansas, the maximum allowable fees, unit values, and conversion factors contained herein do not necessarily reflect the charges or services of any specific type of health care provider, nor are they to reflect the current usual and customary fee for any specific area in the state of Kansas.

All the maximum allowable fees or unit values (with the use of a conversion factor) listed herein represent the maximum payment to be reimbursed for the treatment or service provided. **It is important to remember that reimbursement for any needed services is to be limited to the schedule of charges hereby being adopted or the health care provider's usual and customary charge, whichever is less. All bills submitted for payment must include the actual charges plus the categorization of the charges as per the codes contained in this Schedule of Medical Fees.** There is a provision, however, for allowing a greater fee if it can be clearly established that extraordinary services were required in a particular case. In such a case, this fee is subject to approval by the Director of Workers Compensation.

Medical treatment provided by Out-of-State Providers: For any service (emergency or non-emergency) that is provided by an out-of-state provider, and if a claim is filed under the Kansas Workers Compensation Law, reimbursement for such service is to be limited to the maximum allowable payment contained within the appropriate

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sections of this fee schedule. Thus, any out-of-state provider who willingly provides medical service to an injured worker who is seeking benefits under the Kansas Workers Compensation Law, must realize that said service is to be limited to this fee schedule and should take the necessary steps to receive authorization from the insurance company, employer, or payer prior to providing said service. Prior authorization for such services should be obtained to assure that the processing of a Workers Compensation claim will not be denied. Additionally, absent any pre-approval by the insurance company, employer, or payer, balance billing the injured worker, or any other party, for the services provided is prohibited.

Any service or charge that is not contained within this fee schedule is to be determined by referring to the "Procedures/Services Listed Without Specified Maximum Allowance" rule found within the General Instructions Section. See also the "Procedures Listed Without Specified Maximum Allowance" rule found within each individual section.

STANDARDIZED BILLING FORM: Health care providers, including ambulatory surgical centers, pharmacists, and suppliers of medical equipment and supplies shall use the CMS 1500 form or an equivalent form containing the same information for the billing of their services, drugs, or supplies. Dental offices shall use the ADA-94 form or an equivalent form containing the same information. Hospitals shall use Form UB-92.*** (See Footnote.)**

Any insurance company, employer, or other payer who reduces or denies charges from a provider according to the general instructions, ground rules, unit values, or maximum fees contained within this fee schedule must show the **specific** basis of the reduction or denial by use of an **"Explanation of Benefits"** form. The **specific** general instruction, **specific** ground rule, **specific** unit value or **specific** maximum fee that was used for the reduction or denial must be indicated or identified. When payment is reduced or denied on some other basis, the **"Explanation of Benefits"** form must contain a complete explanation as to why, for example, the service was unreasonable, the service was more appropriately defined by another procedure code, or the service was not related to a compensable injury. When any such reduction or denial occurs, the **"Explanation of Benefits"** form shall also include: 1) the identity of the person or entity that made the decision for the reduction or denial; 2) the identity of the person or entity that is ultimately responsible for payment; and 3) the telephone number of such person or entity where further explanation of the reduction or denial can be obtained. **In the event a controversy arises between the provider and the payer, an attempt should be made by the involved parties to resolve said issue(s). Issues which cannot satisfactorily be resolved should then be referred to the Director of Workers Compensation for review.**

As a further attempt to avoid controversy arising between the provider and the payer for failure to make timely payment for any medical services provided, it is recommended that the insurance company or self-insured employer make payment for any medical services that were provided either: 1) within 30 days of receiving the bill submitted and any necessary documentation required by the fee schedule, or; 2) within 30 days of it being determined that the medical service provided is the result of an injury that is compensable under the Workers Compensation Law.

Where the word "physician" appears within this fee schedule it shall mean, where appropriate, a "health care provider" as defined by the Kansas Workers Compensation Law.

SPECIAL NOTE: The five-digit codes included in this Schedule of Medical Fees (with the exception of the Dentistry Section and the Medical Equipment and Supplies Section) are obtained from *Current Procedural Terminology* (*CPT*®), copyright 2004 by the American Medical Association (AMA). *CPT* is developed by the AMA as a listing of descriptive terms and five-digit codes and modifiers for reporting medical services and procedures performed by physicians.

The responsibility for the content of the Schedule of Medical Fees is with the state of Kansas Division of Workers Compensation and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Schedule of Medical Fees. No fee schedules, basic unit values, relative value guides, conversion factors or scales are included in any part of *CPT*. Any use of *CPT* outside of Workers Compensation Schedule of Medical Fees should refer to the most current *Current Procedural Terminology* which contains the complete and most current listing of *CPT* codes and descriptive terms. Applicable FARS/DFARS apply.

Relative value units for anesthesia services have been excerpted from the *2005 Relative Value Guide,* copyright 2004 by permission of American Society of Anesthesiologists.

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The five-digit codes included in the Dentistry Section of this Schedule of Medical Fees are obtained from the publication of the American Dental Association titled *Current Dental Terminology, CDT-2005.* The following is therefore applicable: *Current Dental Terminology* copyright 2002, 2004 American Dental Association. All rights reserved.

ADDITIONAL SPECIAL NOTE: The Kansas Workers Compensation Law specifically prescribes that an injured employee shall not be liable for any charges above the amount contained within this fee schedule. The respective section of the Kansas Workers Compensation Law (K.S.A. 44-510j) that prohibits an injured employee for being liable for any charges above the amount contained within this fee schedule reads as follows:

> Any health care provider, nurse, physical therapist, any entity providing medical, physical or vocational rehabilitation services or providing reeducation or training pursuant to K.S.A. 44-510g and amendments thereto, medical supply establishment, surgical supply establishment, ambulance service or hospital which accept the terms of the workers compensation act by providing services or material thereunder shall be bound by the fees approved by the director and no injured employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director.

Interpreter Services: If the services of an interpreter are required for the provision of medical care to a hearing impaired, speech impaired, or other person whose primary language is other than English, the following will apply:

- Maximum allowable payment for the first hour or less is limited to $35.00.
- Each additional quarter hour increment of time is to be paid at $8.75 per quarter hour increment.
- Any reimbursement for necessary travel mileage (including any tolls and parking fees actually incurred) is to be at the rate prescribed for compensation of state officers and employees pursuant to K.S.A. 75-3203a.

CONVERSION FACTORS

Any reimbursement for necessary travel mileage (including any tolls and parking fees actually incurred) is to be at the rate prescribed for compensation of state officers and employees pursuant to K.S.A. 75-32The conversion factors applicable to this fee schedule are as follows:

Anesthesia	$48.75
Surgery	$67.95
Radiology	$63.15
Pathology and Laboratory	$75.10
Medicine	$52.42
Physical Medicine and Rehabilitation	$43.80
Medical Nutrition Therapy	$41.19
Acupuncture	$41.19
Osteopathic Manipulative Treatment	$54.43
Chiropractic Manipulative Treatment	$50.75
Special Services and Reports	$42.35
Evaluation and Management Services	$46.33
Home Health Procedures / Services	$25.00
Home Infusion Procedures / Services	$25.00
Dentistry	$35.75
Hospital / Ambulatory Surgical Center	N/A
Medical Equipment and Supplies	N/A
Prescription Services	N/A
Vocational Rehabilitation Services	N/A
Depositions, Testimony, and Medical Records Reproduction	N/A
Ambulance and Aircraft Services	N/A
Nursing Homes / Intermediate Care Facilities	N/A

To determine the maximum fee schedule amount for a procedure, it is necessary to multiply the unit value of the procedure by the dollar conversion factor applicable to the particular section in effect on the date the service was provided. Formula: unit value multiplied by conversion factor = maximum fee schedule amount.

*** Form UB-92 is to gradually be replaced by Form UB-04, beginning March 1, 2007. Either form (UB-04 or UB-92) may be used until May 22, 2007. Starting May 23, 2007, the UB-92 will no longer be accepted.**

GENERAL INSTRUCTIONS

FOR USING THE SCHEDULE

FORMAT

Twenty-two major sections comprise this Fee Schedule: Anesthesia; Surgery; Radiology (including Nuclear Medicine and Diagnostic Ultrasound); Pathology and Laboratory; Medicine; Physical Medicine and Rehabilitation; Medical Nutrition Therapy; Acupuncture; Osteopathic Manipulative Treatment; Chiropractic Manipulative Treatment; Special Services and Reports; Evaluation and Management; Home Health; Home Infusion; Dentistry; Hospital/Ambulatory Surgical Center; Medical Equipment and Supplies; Prescription Services; Vocational Rehabilitation Services; Depositions, Testimony, and Medical Records Reproduction; Ambulance and Aircraft Services; and, Nursing Homes/Intermediate Care Facilities. This Fee Schedule is divided into these sections for structural purposes only. Providers of medical services and/or suppliers are to use the section(s) which contain the procedures they perform, or the services they render.

Also included in this Fee Schedule is a separate section identified as **Appendix B - Quick Reference Table,** which is to be considered only as a supplement to this Fee Schedule. This appendix is provided for use in determining the maximum fee that is associated with a particular procedure code. Note specifically that each maximum fee found therein is calculated by multiplying the respective conversion factor of this Fee Schedule by the unit value of the procedure code.

GROUND RULES

Introductory material, known as Ground Rules, precedes the separate sections of this Fee Schedule and contains the necessary general information, instructions, and general rules with which the user needs to become acquainted before undertaking the use of this Fee Schedule. Familiarity with these general rules, which may include definitions, references, prohibitions, and directions for their proper employment, is necessary for all who use this Fee Schedule. It cannot be emphasized too strongly that these rules need to be read before this schedule is used.

PROCEDURES/SERVICES LISTED WITHOUT SPECIFIED MAXIMUM ALLOWANCE

Some procedures/services are not accompanied by allowable fees. Procedures/services denoted "by report" (BR) in the unit value column are too unusual or variable in the nature of their performance, too new, or too infrequently performed to permit the assignment of a unit value. Fees for such procedures/services need to be justified "by report." The report should contain sufficient supportive information to permit proper identification. Pertinent information should be furnished concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary, etc. For any procedure/service where the unit value is "BR," the health care provider shall establish a charge that is consistent with other unit values shown in the Schedule. The insurance carrier or self-insured employer should review all submitted "BR" amounts to assure that an excessive charge for services provided is not occurring. **Note also that for any procedures/services not listed within this Fee Schedule, the associated charge(s) will need to be substantiated "by report" (BR).**

DEFINITIONS

New Patient: One who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

Established Patient: One who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

Note that no distinction is made between new and established patients in the emergency department. E / M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

GENERAL INSTRUCTIONS

Modifiers: A modifier **(located in Appendix A)** provides the means by which the reporting physician can indicate that a service or procedure, that has been performed, has been altered by some specific circumstance but not changed in its definition or code. Only one modifier should be added to any single five-digit code submitted by an individual health care provider. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

MODIFIER EXAMPLES

1: A physician providing diagnostic or therapeutic radiology services, ultrasound, or nuclear medicine services in a hospital would use modifier -26 to report the professional component, as follows:

73090-26 = Professional component only for an x-ray of the forearm

2: Two surgeons, usually with different skills, may be required to manage a specific surgical problem. The modifier -62 would be applicable. Modifier -62 would be appropriate only when both surgeons are reporting the same code number and descriptor. For instance, a neurological surgeon and an otolaryngologist are working as co-surgeons in performing transsphenoidal excision of a pituitary neoplasm. The first surgeon would report:

61548-62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

AND the second surgeon would report:

61548-62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

A listing of modifiers pertinent to **ANESTHESIA, SURGERY, RADIOLOGY, PATHOLOGY AND LABORATORY, MEDICINE,** and **EVALUATION AND MANAGEMENT** are located in **Appendix A - Modifiers.**